Marple Newtown School District

Out of Network Vision Reimbursement Claim Form

National Vision Administrators (NVA) is the administrator of your vision care plan. We urge you to utilize participating NVA providers who can provide you with significant discounts on goods and services - this gives your benefit a greater value. Also, a Participating Provider will verify your coverage and process your claim for you directly with NVA. When you receive your services you will only have to pay the amount you are responsible for.

If you have selected a non-participating eye care provider, you will be responsible for one-hundred percent (100%) of the cost for your goods and services at the time of service. You must then fill out and submit this claim form along with your detailed receipts to be reimbursed as shown below.

If you have submitted your Out of Network claim to NVA you may use this claim form to be paid the difference between the $35 paid by NVA and the full exam cost.

Employee/Subscriber:

Last Name	First Name	SSN

Full Mailing Address	Telephone Number

Patient:

Last Name	First Name	Date of Birth	Relationship

Provider:

Provider's Name. If you utilize more than one provider (i.e., for exam and then glasses) please list both in the space above.
You must attach a detailed receipt for each provider along with this claim form. The receipt must include the Providers Name, Address and Telephone Number. You can simply attach your receipts, or you can enter the amounts in the space below to calculate the amount you will be reimbursed.

Services	Benefit	Date of Service	Amount Charged	Eligible Amount
Examination	100%			
Lenses and Lens Options	$300			
Frames	$15			
OR				
Contact Lenses (in Leiu of Glasses)	$217			
			Reimbursement:	

Contact Lens Evaluation and Fitting: This is not a covered service.

How to Submit this Claim: Mail or fax this claim form along with your detailed invoice/receipt to **Gallagher Benefit Services, Inc., 100 Matsonford Road, 3 Radnor Corporate Center, Suite 100, Radnor, PA 19087, Fax: 610-627-0256, Phone: 866-515-5899. NOTE: Missing or incomplete information may result in a delay of your request.**

To the best of my knowledge the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses. I understand that Gallagher Benefit Services, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If there are any changes in the provided information, I understand it is my responsibility to notify Gallagher Benefit Services. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit. By submitting this form I certify the above.

Signature _____ Date _____